

Defence Medical Services Department of Community Mental Health – Scotland

Quality Report

DCMH Faslane,
HMS Neptune, Medical Centre
HM Naval Base Clyde
Helensburgh
Argyll and Bute
G84 8HL

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, and information given to us from the provider and patients.

Ratings

Overall rating for this service	Inadequate 
Are services safe?	Requires improvement 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive to people's needs?	Inadequate 
Are services well-led?	Inadequate 

Overall Summary

The five questions we ask about our core services and what we found

We carried out an announced inspection at the Department of Community Mental Health – Scotland (DCMH) between the 12 and 16 March 2018. Overall, we rated the service as inadequate.

We found areas where the DCMH could make improvements. The Chief Inspector of Hospitals recommends that the DCMH addresses the following:

- We found that not all risks had been captured within the risk and issues logs and had not been reflected within the common assurance framework. Governance processes had not been followed and had not mitigated risks.
- The management structure was not being adhered to at Faslane so that leadership roles were unclear. Morale was poor at Faslane and some staff were displaying destructive interpersonal relationships within the management and staff team. This was undermining performance and was not managed at any level.
- Overall staffing arrangements at the team were insufficient to meet targets and relied on the use of a number of locum staff. The team at Faslane was not meeting its targets for routine referrals and there were long waits particularly for high intensity treatment.
- The infrastructure at Kinloss was poor and presented risks to patients. This included open access to clinic rooms, bathrooms and kitchen areas that contained multiple risks. The layout did not promote the privacy or safety of patients and staff. The location at Faslane made access difficult and stressful for both patients and staff. Some patients faced very long journeys to the base which was exacerbated by extensive time to travel into and around the base.

However, we found areas of good practice:

- The team consisted of a full range of mental health disciplines working under the clinical leadership of a consultant psychiatrist. The team worked in partnership with other agencies to manage and assess patient needs and risks.
- All referrals were clinically triaged by the mental health team to determine whether a more urgent response was required and to monitor whether patients' risks had increased.
- Systems were being set up to better capture governance and performance information and to learn from adverse events. Incidents reported had been appropriately investigated and used to inform practice.
- Staff at Kinloss reported that their manager was approachable and supportive of their work which resulted in high morale. Staff at Kinloss stated that they were part of a cohesive team and felt supported by their manager and colleagues.
- Staff showed us that they wanted to provide high quality care. We observed some very positive examples of staff providing practical and emotional support to people. Patients said they were well supported and that staff were kind and enabled them to get better.

Professor Edward Baker

Chief Inspector of Hospitals

Are services safe?

Requires improvement

We rated the DCMH as requires improvement for safe because:

- Overall staffing arrangements at the team were insufficient to meet targets and relied on the use of a number of locum staff. The team at Faslane was not meeting its targets for routine referrals and there were long waits particularly for high intensity treatment. We were concerned that these significant delays meant that patients were at risk of a longer recovery or of further deterioration in their condition.
- Low staffing levels meant that the team was less able to offer peripatetic clinics resulting in significant travelling for patients to access appointments at Faslane or Kinloss.
- The infrastructure at Kinloss was poor and presented risks to patients. This included open access to clinic rooms, bathrooms and kitchen areas that contained multiple risks. The layout did not promote the privacy or safety of patients and staff.
- We had concerns at Faslane that a vulnerable patient had not been followed up appropriately when they failed to attend an appointment.
- Staff were expected to undertake a number of courses as part of mandatory training. At Faslane, fewer than 75% of staff had completed the training for six of these courses.

However:

- All referrals were clinically triaged by the mental health team to determine whether a more urgent response was required and to monitor whether patients' risks had increased.
- Individual patient risk assessments were thorough and proportionate to patients' risks. The team had developed a process to share concerns about patients in crisis or whose risks had increased.
- Incidents reported had been appropriately investigated and used to inform practice.

Are services effective?

Good

We rated the DCMH as good for effective because:

- Clinicians were aware of current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Patients were able to access a range of psychological therapies as recommended in NICE guidelines.
- The team used a range of outcome measures throughout and following treatment. These indicated improved outcomes following treatment.
- The team consisted of a full range of mental health disciplines working under the clinical leadership of a consultant psychiatrist. The team worked in partnership with other agencies to manage and assess patient needs and risks.
- Staff were able to access developmental training and a range of clinical support.

However:

- Consent was sort from patients but was not always clearly documented.

Are services caring?

Good

We rated the DCMH as good for caring because:

- Staff showed us that they wanted to provide high quality care. We observed some very positive examples of staff providing practical and emotional support to people.
- Patients said they were well supported and that staff were kind and enabled them to get better. Patient satisfaction was also demonstrated by positive patient experience survey results and the feedback we received.
- Patients told us that staff provided clear information to help with making treatment choices. Care records reviewed demonstrated the patient's involvement in their care planning.

However:

- Care plans were not routinely given to patients. In practice, plans were in existence but verbally agreed. Patients would benefit from a written reminder of the treatment goals.

Are services responsive to people's needs?

Inadequate

We rated the DCMH as inadequate for responsive because:

- The team at Faslane was not meeting its waiting time targets for routine referrals and there were long waits, particularly for high intensity treatment.
- We were concerned that processes were not always followed if a patient did not attend an appointment. There were higher numbers of missed appointments than was expected. .
- The infrastructure at Kinloss did not promote the privacy of patients or the safety of staff.
- The location at Faslane made access difficult and stressful for both patients and staff. For example, patients undertaking therapy within hearing of the firing range. Some patients faced very long journeys to the base which was exacerbated by extensive time to travel into and around the base.

However:

- Where a known patient contacted the team in crisis during office hours the team responded positively.
- The team monitored the length of the care pathway. In 88% of cases patients were discharged within nine months of commencing treatment.
- The team had a system for handling complaints and concerns. Patients felt that they would be listened to should they need to complain. Learning was captured from complaints.

Are services well-led?

Inadequate

We rated the DCMH as inadequate for well-led services because:

- We found that not all risks had been captured within the risk and issues logs and had not been reflected within the common assurance framework. Governance processes had not been followed and had not mitigated risks.
- Insufficient staff of the right experience and a lack of leadership hampered the team's ability to meet performance targets at Faslane.
- The management structure was not being adhered to at Faslane so that leadership roles were unclear. Morale was poor at Faslane and some staff were displaying destructive interpersonal relationships within the management and staff team. This was undermining performance and was not managed at any level.

- The infrastructure at Kinloss was poor and the location at Faslane made access difficult and stressful for both patients and staff. These issues had not been resolved despite the management team's awareness of the impact of these issues.

However:

- Staff at Kinloss reported that their manager was approachable and supportive of their work which resulted in high morale. Staff at Kinloss stated that they were part of a cohesive team and felt supported by their manager and colleagues.
- A range of audit and quality improvement projects were being undertaken.

Our inspection team

Our inspection team was led by a CQC Head of Inspection Julie Meikle and Inspection Manager Lyn Critchley. The team included one inspection manager and one inspector and a specialist military mental health nursing advisor.

Background to Department of Community Mental Health – Scotland

The department of community mental health (DCMH) Scotland provides mental health care to a population of approximately 10,500 serving personnel from across all three services of the Armed Forces. The catchment for the service includes all service personnel based in Scotland and those who have returned to Scotland on home leave. The service operates from a main base at HMS Neptune (Faslane hub) with a secondary service based at Kinloss Barracks. DCMH Faslane supports the number one defence priority - the Continuous At Sea Deterrent. Staff also offered a small number of sessions at Leuchars Station, Redford Barracks near Edinburgh, RAF Lossiemouth, Kentigern House (Army Personnel Centre) in Glasgow and HMS Caledonia in Rosyth with the majority of patients travelling to HMNB Faslane or Kinloss Barracks to receive their service. At the time of our inspection the DCMH active caseload was approximately 191 patients.

The department aims to provide occupational mental health assessment, advice and treatment. The aims are balanced between the needs of the service and the needs of the individual, to promote the well-being and recovery of those individuals in all respects of their occupational role and to maintain the fighting effectiveness of the Armed Services. The service is clinic based with the majority of appointments being held at the clinics at HMNB Faslane or Kinloss Barracks.

The service operates during office hours. There is no out of hours' service directly available to patients: instead patients must access a crisis service through their GPs or via local emergency departments. The team participates in a National Armed Forces out of hours' service on a duty basis. This provides gatekeeping and procedural advice regarding access to beds within the DMS independent service provider contract with NHS providers.

RAF personnel within the team also form part of Tactical Medical Wing. On a duty basis they may be required to perform psychiatric aeromedical evacuation of overseas Armed Forces personnel.

Why we carried out this inspection

The Care Quality Commission (CQC) carried out this inspection as one of a programme of inspections at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability. Defence Medical Services (DMS) are not required to register with CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. Consequently DMS services are not subject to inspection by CQC and CQC has no powers of enforcement. However, where CQC finds shortfalls in the quality of services during inspection, we will report them by making a recommendation for action to the Surgeon General's office.

We carried out a comprehensive inspection of this service. The Department of Community Mental Health – Scotland was not subject to a CQC inspection as part of the previous inspection programme of DMS facilities.

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information the DCMH and the Defence Medical Services had shared with us about the service. This included: risk registers and the common assurance framework, complaints and incident information, clinical and service audits, patient survey results, service literature, staffing details and the service's timetable.

We carried out an announced inspection between 12 and 16 March 2018. During the inspection, we:

- looked at the quality of the teams' environments;
- observed how staff were caring for patients;
- spoke with 12 patients who were using the service;
- spoke with the management team and the regional director;
- spoke with 16 other staff members; including doctors, nurses, a psychologist and social workers;
- met with two lead GPs and two pharmacy leads;
- reviewed 25 comment cards from patients;
- looked at 19 clinical records of patients;

- looked at a range of policies, procedures and other documents relating to the running of the service;
- observed two clinics and two multidisciplinary team meetings;
- attended business and governance meetings;
- examined minutes and other supporting documents relating to the governance of the service.

Defence Medical Services

Department of Community Mental Health – Scotland

Detailed findings

Are services safe?

Requires improvement

Our findings

Safe and clean environment

- There was an environmental risk assessment in place at both of the team's bases. These highlighted risk factors including the presence of ligature anchor points and other relevant clinical environmental risks. General health and safety and fire safety checks were in place.
- At Faslane, the team was located on the second floor of a building shared with the Naval base's GP practice. This space was distinct from the GP team and was found to be well decorated and clean.
- At Kinloss Barracks, the team was also co-located with the barrack's GP practice. However, the clinic rooms used by the GP practice staff were located within the mental health team's corridor and were open at the time of the inspection. In addition, the kitchen area and bathrooms were also found to be open. While these issues had been highlighted within the environmental risk assessment and risk register we were concerned that they presented a high level of risk. For example, we observed a sharps box containing used needles and blood samples within a clinic room and the emergency response equipment in a corridor. We also observed a large number of self-harm risks in the kitchen and bathrooms.
- At Kinloss Barracks, the mental health team corridor had open access to any visitors. We were concerned that patient privacy could be compromised and that staff may be at risk when lone working by the shared use of the facility.
- The facility at Kinloss was clean, but was tired in places. At the time of the inspection, decorators were addressing areas of peeling paint at the building. Carpets were noted to be stained in some areas. The GP practice manager confirmed a business case was in place to replace these.
- Both buildings were fitted with a safety alarm for staff to use in the event of an emergency.
- The mental health teams did not have their own clinic rooms as physical health examinations were

undertaken by the GP services.

- The team had access to an infection prevention and control nurse and staff received infection prevention training. Hand wash facilities and hand gels were available and staff adhered to infection control principles, including handwashing. Cleaning audits were in place at both bases.
- Equipment logs were in place. Equipment such as the eye movement desensitization and reprocessing (EMDR) sensors were found to be clean and had been serviced. Portable appliance testing had been undertaken.

Safe staffing

- Following a DMS review in 2015 (DMS 20) a decision was made to employ civilian staff to support military staff to aid consistency within services. However, recruitment to posts had been a challenge and had meant high use of locum staff. The practice manager explained that there could be significant delays in the recruitment process due to this being undertaken by another part of the Armed Services.
- At the time of our inspection, overall staffing arrangements at the team were insufficient to meet targets and relied on the use of a number of locum staff. Overall the vacancy level was 28%. There were five nursing vacancies from the establishment of 11 posts. The team was mitigating these high vacancy rates with the use of regular locum staff where possible. At the time of our inspection there were three locum nurses, one locum psychiatrist, one locum social worker and one locum psychologist.
- At the time of the inspection the team's active caseload was 191 of which 120 were at Faslane and 71 at Kinloss. A further 47 people were awaiting treatment. It was noted that overall waiting lists had decreased since December 2017 when there was a peak of 63 people. However, delays for high intensity treatment were up to 263 days. The delay was due to not all staff being able to deliver these treatments. At Faslane, between September and November 2017 the average waiting time from referral to treatment was 78 days. Faslane had the longest waiting time of all DCMHs which together had an overall average of 49 days. We were concerned that these significant delays meant that patients were at risk of a longer recovery or of further deterioration in their condition.
- The management team told us that a key risk was a lack of service in the East coast area of Scotland. This was due to current staffing levels meaning the team was less able to offer peripatetic clinics in the area. This meant significant travelling for patients to access appointments at Faslane or Kinloss.
- The waiting list to see a psychiatrist was 14 patients at February 2018. The longest wait was 91 days. The team stated this delay was due to patients awaiting assessment for suitability to remain in the military which was dependent on completion of other procedures. We observed that there was rapid access to a psychiatrist in an emergency.
- Thirty-one training courses were classed as mandatory. We saw that regular locum staff received training similar to permanent staff. At the time of the inspection all staff at Kinloss were up to date with training. At Faslane, compliance ranged from 100% for induction, well-being, mental health awareness and health and safety to 33% for environmental awareness. Six courses fell below 75% compliance: infection control, healthcare governance, environmental awareness, defence information and information governance, business continuity and DMICP (defence information systems).

Assessing and managing risk to patients and staff

- Referrals came to the team from medical officers, GPs and other DCMHs. These were indicated as either urgent or routine. Urgent referrals were considered by the end of the next working day. The target to see patients for a routine referral was 15 days. A senior nurse or duty worker was available each working day to review all new referrals. Routine referrals were clinically triaged by the nurse to determine whether a more urgent response was required. All fresh cases were also taken to the weekly multidisciplinary team meeting to ensure an appropriate response.

- Once a patient was accepted by the team a thorough risk assessment was undertaken and this was reviewed by the multi-disciplinary team. The team operated a process to share concerns with colleagues about specific patients whose risks had increased. This included risks due to safeguarding concerns. Where a known patient contacted the team in crisis, the team responded swiftly. However, we had concerns for two occasions at Faslane where a vulnerable patient may have been at risk. One patient who had self-harm risks had not attended an appointment in February 2018 and this had not been appropriately followed up. A further patient had been transferred to the team from another service where they had been part way through a course of EMDR (eye movement desensitization and reprocessing) treatment. This patient had been placed on the waiting list to recommence this treatment for over 90 days at the time of our inspection.
- The Ministry of Defence had an up to date policy for child protection. However, we were told that the adult safeguarding policy had not been updated and did not meet the latest guidance. This meant that there could be gaps in understanding and action. There was however a local procedure for reporting adult safeguarding concerns.
- The team's social workers acted as the designated safeguarding lead at the respective bases. Adult safeguarding was not part of the DMS's mandatory training requirements, however, the Scottish equivalent of levels 1 to 3 child protection were. All required staff had undertaken the equivalent of level 3 child protection training via the local authority. The lead social worker confirmed that the local authority, who had delivered the child protection training, were going to provide bespoke adult safeguarding training.
- Arrangements were in place for logging which staff were in or out of the building at both bases. However, we were concerned that the treatment rooms had open access to patients and unknown visitors.
- The DCMH did not dispense medication. Prescribing was only undertaken by the team's clinical lead via an electronic prescribing system. Otherwise the team made a recommendation to the patient's GP who prescribed the medication. No delays were reported in patients receiving their medication.
- There were written procedures for response in a medical emergency. All staff had received annual basic life support and defibrillator training and most had undertaken anaphylaxis training. The team did not have its own defibrillator at either base but these were available at the co-located GP practices.
- Business continuity plans for major incidents, such as power failure or building damage were in place. The plans included emergency contact numbers for staff. The Faslane facility is located within a high security naval base. Detailed security plans and training were available to staff.

Track record on safety

- Between October and December 2017 there were 18 significant events across the service: 15 at Faslane and 3 at Kinloss. At the time of the inspection there were four open investigations. The clinical lead told us that the inaccessibility of DCMH Faslane, due to its location at a secure naval base, was the key theme. Other key themes had included issues with administration processes and IT, resource issues and problems with infrastructure. While these events had not directly affected patient safety they had impacted on treatment.

Reporting incidents and learning from when things go wrong

- The team used the standardised DMS electronic system to report significant events, incidents and near misses. Staff received training at induction regarding the processes to report significant events and were aware of their role in the reporting and management of incidents. The team had recently set up a monthly 'learning from events' meeting at which all open serious events were tracked and decisions about further investigation were made. This was mandatory for all staff.

Learning and recommendations were shared. We noted from the minutes that significant events were also discussed at monthly governance and weekly business meetings, including the outcome and any changes made following a review of the incident.

Are services effective?

Good

Our findings

Assessment of needs and planning of care

- Formal assessment was undertaken once a patient's referral was accepted by the team. Following this, a thorough assessment of the patient's needs was undertaken. In practice, clear care and treatment plans were developed and this information was shared verbally with patients. However, formal care plans were not formulated. Patients may benefit from a written record of their treatment goals.
- Information was stored securely. The team had access to an electronic record system which was shared across all DMS healthcare facilities. Paper records were also scanned on to the system to ensure easy access and safe storage. This system facilitated effective information sharing across mental health and GP services.

Best practice in treatment and care

- Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. NICE and other guidance was reviewed within team and governance meetings.
- The team employed two psychologists and some nurses who were also trained in a range of psychological treatments. Patients were therefore able to access a range of psychological therapies as recommended in NICE guidelines for depression, post-traumatic stress disorder (PTSD) and anxiety. Treatments included the use of cognitive behavioural therapy, cognitive analytical therapy and eye movement desensitization and reprocessing. However, access was limited due to not all staff being trained in these therapies.
- As an occupational mental health service the team's role was to assist patients to retain their occupational status or to leave the armed services. Patients could also use the team during the first six months following discharge from the military. The team worked closely with the Veterans Welfare Agency and the Armed Forces Transition Service to ensure effective support with employment, housing and wider welfare.
- The team was developing therapeutic groups to offer more timely access to patients who required lower level and more practical intervention however these had not commenced at the time of the inspection.
- Physical healthcare monitoring, including monitoring of the effects of antipsychotic medication, was undertaken by the patient's GP practice. Staff described the advice and support they would give to colleagues in GP services around specialist mental health monitoring.
- The team used a range of outcome measures throughout and following treatment. These included work and social adjustment scale, patient health questionnaire, generalised anxiety disorder scale, the PTSD checklist and the alcohol use disorders identification test.
- A range of audits were undertaken by the team. The team also participated in audits with the co-located GP practices. These included case notes audits, caseload analysis, care pathway evaluation and supervision audits as well as infection control, cleanliness and environmental audits. The clinical lead was undertaking an audit on the effects of anti-psychotic prescribing at the time of the inspection. QI projects had also been undertaken looking at the 'joy of work' and the effect of an early psychiatrist appointment on treatment outcomes.

Skilled staff to deliver care

- The team consisted of a full range of mental health disciplines working under the clinical leadership of a consultant psychiatrist. These included nurses, psychologists and social workers.

- New staff, including locums, received a thorough induction. Development training, such as in cognitive behaviour therapy and EMDR, was available to some staff. Some nursing staff were undertaking additional academic qualifications financed by the service. The team also hosted student nurses training within the Armed Forces. At Kinloss some bespoke training had been delivered by members of the team such as a session on mindfulness.
- Staff had support through weekly multidisciplinary, caseload management and business meetings. Staff were also involved in monthly governance and learning from events meetings. Staff we spoke with at Kinloss confirmed that they had protected time for supervision and professional development. Staff were positive about their supervision and felt well supported through the team structure. At Faslane, some staff stated that caseload supervision did not always happen as planned. An audit in February 2018 found that only 70% of clinicians were receiving regular caseload management.

Multidisciplinary and inter-agency team work

- Care and treatment plans were reviewed regularly by the multi-disciplinary team in weekly team meetings.
- The team worked in partnership with a range of services both within and outside the military. These included liaison with the NHS providers who are independent service providers of psychiatric beds. The team had a liaison officer whose role it was to work with the NHS team to ensure effective care and discharge from the service.
- As an occupational health service the team worked closely with a range of agencies to support military personnel to leave the Armed Forces. This role included access to employment, housing and welfare organisations including the Defence Medical Welfare Service and Armed Forces Transition Service. Where necessary, when handing care over on discharge of a patient from the services, the team met with the receiving NHS teams.

Adherence to the Mental Health legislation

- Staff were knowledgeable about relevant mental health legislation.
- The Mental Health Act was used very infrequently at the service. Should a Mental Health Act assessment be required the provider worked with local NHS provider to access this through civilian services. A patient was admitted to hospital during the inspection. We observed good relationships between the DCMH and the NHS provider which facilitated timely access to the bed.

Good practice in assessing capacity and consent

- Staff did not receive specialist training in the The Adults with Incapacity (Scotland) Act 2000. There was not a specific policy on the Act that staff were aware of and could refer to. However, all staff spoken with had an awareness of the principles of the Act and the need to ensure capacity and consent.
- We did not find any evidence of capacity assessments in any of the records we reviewed. In line with the principles of the Act, staff assumed capacity unless there was evidence to suggest otherwise. However, in a consultation that we observed staff did fully consider the patient's capacity and consent in making decisions about admission to hospital.
- We observed staff discussing consent to treatment with patients. In most cases we found records of consent to share information. However, we did not find records of consent to treatment in all records. It is the individual healthcare professional's responsibility to assure capacity and gain consent and this should be considered on an ongoing basis.

Are services caring?

Good

Our findings

Kindness, dignity, respect and support

- Staff showed us that they wanted to provide high quality care. We observed some extremely positive examples of staff providing practical and emotional support to people.
- We saw staff that were kind, caring and compassionate in their response to patients. We observed staff treating patients with respect and communicating effectively with them. This included both clinical and administrative staff. All of the patients we spoke with told us that staff were kind and supportive, and that they were treated with respect.
- Staff demonstrated that they were knowledgeable about the history, possible risks and support needs of the people they cared for. We saw staff working with patients to reduce their anxiety and behavioural disturbance. This was particularly apparent regarding staff's support around the challenges that patients faced in accessing the team base at Faslane.
- Confidentiality was understood by staff and maintained at all times. Staff maintained privacy with people, who were asked if they would like their information shared with their relatives, within the chain of command and other bodies, including CQC. Information was stored securely, both in paper and electronic format.

The involvement of people in the care they receive

- Care plans were not routinely given to patients as is DMS practice. However, in practice, plans were verbally agreed with patients. Patient we interviewed and feedback reviewed suggested staff provided clear information to help with making treatment choices. Care records reviewed demonstrated the patient's involvement in their care planning. Patients may benefit from a written record.
- The majority of patients we spoke with did not want involvement of their families. However, three patients confirmed their families had been involved with their permission. We spoke with one relative during the inspection who was very positive about care provided in an emergency. Relative's needs were noted to be considered within patients notes.
- Information was available at the service about a range of organisations that would provide advice and support to serving and former Armed Forces personnel. Staff told us about a number of positive relationships with support organisations. Social workers confirmed that some patients had been supported by advocacy organisations where required.
- The DCMH undertook a patient experience survey on an ongoing basis. This was collated and analysed on a quarterly basis. In the preceding three months, 100 people had participated in the survey. This showed a high and increasing level of satisfaction. In February 2018, 100% of patients would recommend the service to friends and family; 100% felt they were treated with respect and kindness; 96% felt they would be listened to if they complained and felt involved in decisions regarding their care; 95% felt the appointment was at a convenient time and 99% agreed their appointment was at a convenient location. However, 85% of patients stated that they were not seen on time and 95% said they had sufficient time during their appointment to discuss their care fully.

Are services responsive to people's needs?

Inadequate

Our findings

Access and discharge

- The service operated during office hours. There was no out of hours' service directly available to patients: instead patients had to access a crisis service through their GPs or via local emergency

departments. Where a known patient contacted the team in crisis during office hours the team responded promptly. We observed two occasions when this occurred during the inspection, in both cases the response to the patient was exceptional.

- The team participated in a National Armed Forces out of hours' services on a duty basis. This provided gatekeeping and procedural advice regarding access to beds within the DMS independent service provider contract with NHS providers.
- At the time of the inspection two patients were in beds within the NHS: a further patient was admitted during the inspection. We observed good relationships between the DCMH and the NHS provider which facilitated timely access to the bed. The team attended the ward round and met with the patient on a weekly basis when DCMH patients were admitted as inpatients.
- Clear referral pathways were in place. Referrals came to the team from medical officers, GPs and other DCMHs. These were indicated as either urgent or routine. Urgent referrals were considered by the end of the next working day. The target to see patients for a routine referral was 15 days. A senior nurse or duty worker was available each working day to review all new referrals. Routine referrals were clinically triaged by the nurse to determine whether a more urgent response was required. All fresh cases were also taken to the weekly multidisciplinary team meeting to ensure an appropriate response.
- Information provided showed that in December 2017 the DCMH was meeting all of its targets for urgent referral. The managers explained that this had been an improvement on performance at Faslane on previous months.
- The information received from the team ahead of the inspection showed that the team had received 21 routine referrals during December 2017. The team at Kinloss had not missed this response target in the previous 12 months. The team at Faslane had missed the response time to these in 7 cases (33%). This had deteriorated on previous months. In October 2017 the team had met 89% of the target and in November 72%. However, in January 2018 only 38% of the target was met. This improved slightly to 57% in February 2018.
- The team expressed concern that the rate of referrals was rising and therefore they would be unable to meet the additional need. They stated that Scotland had the highest rate of new referrals across DCMHs during 2017. We reviewed admission and discharge figures for 2017. These indicated that there were 247 more patients admitted than discharged during the period.
- At the time of the inspection the team's active caseload was 191. 120 at Faslane and 71 at Kinloss. A further 47 people were awaiting treatment at Faslane. It was noted that overall waiting lists had decreased since December 2017 with a peak of 63 people. However, delays for high intensity treatment were up to 263 days. For low intensity treatment delays were up to 77 days. At Faslane, between September and November 2017 the average waiting time from referral to treatment was 78 days. Faslane had the longest waiting time of all DCMHs which together had an overall average of 49 days. The DCMH provided information following the inspection that stated that 47% of those on the high intensity waiting list were already undergoing low intensity interventions. However, we were concerned that a patient had been transferred to the team from another service where they had been part way through a course of EMDR (eye movement desensitization and reprocessing) treatment. This patient had been placed on the waiting list to recommence this treatment for over 90 days at the time of our inspection.
- The clinical team told us that the high intensity waits particularly related to limited staff being trained in EMDR and CBT (cognitive behaviour therapy) at Faslane. Currently only the psychologist and two nurses could undertake this work.
- The clinical lead confirmed that all patients with a care pathway of over three months would be scheduled for a psychiatric appointment. At February 2018, the waiting list to see a psychiatrist was 14 patients. The longest wait was 91 days. The team stated this delay was due to patients awaiting assessment for suitability to remain in the military which was dependent on completion of other procedures. We observed that there was rapid access to a psychiatrist in an emergency.
- The team monitored the length of the care pathway. In 88% of cases the patients were discharged

within nine months of commencing treatment. 68% of patients were discharged within six months of commencing treatment.

- The team undertook a 'care pathway audit' in December 2017 to look at whether GPs were informed of the need to regularly review patients in the gap between initial assessment by the DCMH and the initiation of therapy. At this time there had been an improvement going from 15% compliance in May to July 2017 to 73% for the re-audit period. A further re-audit was being undertaken at the time of the inspection. Anecdotally the team thought there had been improvement however there was concern that some patients may still 'fall through the gap', causing potential risks to patient safety.
- Within the Armed Forces, personnel can be ordered to attend for a medical appointment. However, personnel do not have to accept treatment. The team had a procedure regarding following up patients who did not attend their appointment (DNA process). The team confirmed that usually only patients who had been deployed to other duties at short notice did not attend. However, the DNA rates at February 2018 were at 13% against a target of less than 10%. We also had concerns about a patient at Faslane who had self-harm risks. The patient had not attended an appointment in February 2018 and this had not been appropriately followed up. This was addressed during the inspection.
- Both staff and patients told us about the difficulties in accessing the team at Faslane. The team is based at HMS Neptune which supports the number one defence priority - the Continuous At Sea Deterrent. The base is therefore secure and it is challenging for patients who are not stationed at the base to access as they do not have the right level of security clearance. Staff confirmed that they inform patients coming to the base to allow an extra two hours to clear security checks however despite this, at times, people cannot get to their appointment on time. We observed this during the inspection and found further references within patient files. In addition, the DCMH is stationed approximately 1 mile from the base's entrance, this can add to the time delay in reaching the DCMH base as personal transport through the base was not permitted..

The facilities promote recovery, comfort, dignity and confidentiality

- Both DCMH bases were accessible to people with a disability.
- There were sufficient treatment rooms at the time of the inspection. However, the team expressed concern about space should additional staff be recruited. The team at Faslane were looking at better ways to use the space at the base at the time of the inspection.
- Dignity and privacy were compromised at Kinloss by the shared use of the facility with the GP practice and poor soundproofing in treatment rooms.
- At Faslane the DCMH building is located within hearing of the base's firing range. Both patients and staff expressed concern regarding the impact this had on the delivery of therapeutic interventions.
- Information was available in public areas on treatments, local services, patients' rights, and how to complain.

Meeting the needs of all people who use the service

- The team was able to offer flexible appointment times during office hours. Patients confirmed that they were given time off to attend appointments and the chain of command was supportive of this. The DCMH undertook a patient experience survey on an ongoing basis. In February 2018, 95% felt the appointment was at a convenient time. However, only 85% of patients stated that they were seen on time and only 95% said they had sufficient time during their appointment to discuss their care' fully. The staff told us that review appointments were limited to 60 minutes and assessments to 90 minutes. Staff told us that this was not always sufficient time and could be hindered further by delays due to difficult access of the team base.
- The DCMH serves all patients across Scotland. Some patients told us that their appointment meant considerable travel. The management team told us that a key risk was a lack of service in the East coast area of Scotland. This was due to current staffing levels meaning the team was less able to offer

peripatetic clinics in the area. This meant significant travelling for patients to access appointments at Faslane or Kinloss. Some patients confirmed that they had travelled for up to four hours to attend the appointment.

Listening to and learning from concerns and complaints

- The team had a system for handling complaints and concerns. The practice manager was the designated person responsible for managing all complaints. A policy was in place and information was available to staff. Staff demonstrated awareness of the complaints process and had supported patients to raise concerns.
- Patient waiting areas had posters and leaflets explaining the complaints process. Patients spoken with understood how to make a complaint. All felt they would be listened to if they complained. The patient experience survey in February 2018 found that 96% of patients felt they would be listened to if they complained.
- In the 12 months prior to our inspection there had been eight complaints; three were regarding the care received from staff. Others related to waiting lists, delays in treatment and time taken to diagnosis. One complaint related to a failure to follow process regarding a previous complaint.
- All complaints, whether written or verbal, were recorded in the complaints log. The practice manager confirmed that she had fully investigated five of the complaints and was investigating the other three. One complaint had resulted in an armed service complaint which was being investigated by the base commander's office. No complaints had been made to the Armed Forces Ombudsman. We reviewed two complaints in detail and found responses to be open and apologetic. The practice manager had offered to meet with both complainants.
- Staff received feedback on complaints and investigation findings in the 'learning from events' meeting, business and governance meetings. We saw evidence of information sharing in meeting minutes.

Are services well-led?

Inadequate

Our findings

Vision and values

- The DCMH leadership team told us of their commitment to deliver quality care and promote good outcomes for patients. The teams mission was to:
 "...provide assessment; treatment and onward referral for service personnel experiencing difficulties associated with their medical, occupational, environmental and social circumstances. The aim of DMHS is to provide service personnel with speedy access to skilled effective help and treatment that is flexible and based around their individual needs. The approach is one of recovery and rehabilitation, ensuring that, wherever possible, service personnel are maintained in their primary role or are returned to duty as soon as clinically indicated. If the individual is unable to return to work, they will be supported and guided.....to make a smooth, seamless and effective transition back into civilian life."
- However, not all staff at Faslane were clear that the service was fully delivering this vision.

Good governance

- The common assurance framework (CAF), a structured self-assessment internal quality assurance process, formed the basis for monitoring the quality of the service. The practice manager, in conjunction with the management team, kept it under review and updated it when necessary.

- The team had an overarching governance framework to support the delivery of the service, to consider performance and ensure continuous learning. The team had a monthly governance meeting which all staff attended. The meeting considered good practice guidelines, policy development, risk issues, learning from complaints and adverse events, team learning and service development. In addition, the team had developed a 'learning from events' meeting to consider more in-depth quality and safety information.
- The team manager at Kinloss and the practice manager at Faslane were the nominated risk managers. Risk and issues were reviewed quarterly or as identified and logged on the regional headquarters risk and issues registers. These were overseen by the regional operations manager. The risk and issues logs included: the challenges of access to the base for visiting patients and locums, parking issues at the base and staff travel times for Faslane. For Kinloss, the building state, ligature points, risk of open access to staff and patients' dignity, and limited access to a psychiatrist. In addition the environmental risk log for Kinloss included other risks such as the open access to clinic rooms and the kitchen.
- Systems and processes were being set up to better capture governance and performance information, although these had not yet been fully implemented. Work had been undertaken to capture and share learning from adverse events and had led to some changes in practice. Local processes had been developed, including the development of incident and complaints, training and supervision logs and local procedures for managing referrals and safeguarding. Partnership working with other parts of the defence medical services, NHS and voluntary groups was effective.
- Patient experience had been consistently good with most negative feedback relating to access arrangements and infrastructure. We observed some good care for patients throughout the inspection.
- We found that not all risks had been captured within the risk and issues logs and had not been reflected within the common assurance framework. Governance processes had not been followed and had not mitigated risks.
- We were particularly concerned that:
 - There was no clear leadership at Faslane despite attempts to clarify roles and responsibilities. Job roles and lines of accountability for staff were not clearly defined. This meant there was a lack of clarity regarding who was responsible for what and staff vied with each other for control.
 - Morale was very poor at Faslane and staff were acting out destructive interpersonal relationships within the management and staff team. This was undermining performance and was not managed at any level.
 - Insufficient staff of the right experience and a lack of leadership hampered the team's ability to meet performance targets at Faslane. Targets for response to routine referrals were not being met and there were extremely long waits for high intensity treatment..
 - Recruitment had proved challenging and the team therefore relied heavily on the use of locum staff.
 - While recent sickness levels were stated to be good other leave, staffing levels and staff travelling had an impact on service delivery.
 - The infrastructure at Kinloss was poor and on many levels a risk to patients. This included open access to clinic rooms, bathrooms and kitchen areas that contained multiple risks. The layout did not promote the privacy of patients or the safety of staff.
 - The location at Faslane made access difficult and stressful for both patients and staff. For example, patients undertaking therapy within hearing of the firing range. Some patients faced very long journeys to the base which was exacerbated by extensive time to travel into and around the base. This was especially a concern for junior ranks.

Leadership, morale and staff engagement

- The management team consisted of a clinical lead, a team manager at Kinloss, a lead psychologist, a lead social worker, a band 7 civilian nurse at Faslane and a practice manager. The Faslane structure had a gap for a department manager, which had not been permanently filled for two years. At the time of the inspection a military nurse was acting up in this role on a short term basis to perform aspects of healthcare governance. Additional roles had also been taken on by the clinical lead and the band 7 nurse to support this.
- Staff at Kinloss reported that their manager was approachable and supportive of their work. Staff

morale was very good and staff were clear regarding their manager's and their own roles and responsibilities. Staff stated that they were part of a cohesive team and felt supported by their manager and colleagues.

- We found that the management structure at Faslane and leadership roles were unclear. This view was supported by the staff team. Staff stated that morale was poor but had improved slightly in recent months. Some staff were concerned about destructive interpersonal relationships within the management and staff team and suggested that these affected the performance of the team. This concern was acknowledged by the management team. The management team stated that they had held a meeting to discuss job roles in an attempt to ensure better clarity of roles and responsibilities and had thought that progress had been made. However, there were no further meetings and leadership team knew that there had been no progress.
- During the inspection, we met with the regional director for Scotland. He acknowledged the concerns we had about the leadership at Faslane and said that this had been an issue over several years. He confirmed that internal structures had been put in place to address these concerns. These had included a mentoring visit that had occurred towards the end of 2017. However, this was yet to result in action.
- A whistleblowing process was in place that allowed staff to go outside of the chain of command. Staff knew about the whistleblowing process however some staff stated that they would not feel confident to use this. There had been two reported cases of whistleblowing and bullying at the team. These had not been resolved effectively.
- All staff attended team meetings and monthly governance meetings. Staff told us that new developments were discussed at these meetings and they were offered the opportunity to give feedback on the service and input into service development.

Commitment to quality improvement and innovation

- A range of audits were undertaken by the team. The team also participated in audits with the collocated GP practices. These included case notes audits, caseload analysis, care pathway evaluation and supervision audits as well as infection control, cleanliness and environmental audits.
- The clinical lead was undertaking an audit on the effects of anti-psychotic prescribing at the time of the inspection.
- Quality improvement projects had also been undertaken looking at the 'joy of work' and the effect of an early psychiatrist appointment on treatment outcomes.